

SERVICE PROVIDER AGREEMENT

Nebraska Department of Health and Human Services

Section I

Check Appropriate Box and Write Provider Number

☒ Agency FID 203615736 ☐ Individual Provider Social Security Number _____
Name FID Issued To: CARING PEOPLE SUDAN

Section II

Provider Name: (First) _____ (Middle) _____ (Last) _____ Birthdate: _____

CARING PEOPLE SUDANProvider Street Address, City, State & Zip: 1941 So. 42nd St., Ste. 402 Omaha, NE 68105Mailing Address if Different from Location: 2523 Himebaugh Ave., Omaha, NE 68105Business Telephone: _____ Home Telephone: 402-594-9901Appropriate Licensure: PSCLocation of Service Provision if Different than Above: Designated locations as authorized by casemanagers

Par. 1 This Agreement between the Nebraska Department of Health and Human Services (hereinafter the Department) and CARING PEOPLE SUDAN, a service provider, governs the provision of the following service(s) checked below as defined in the Department of Health and Human Services Program Manual, Nebraska Administrative Code (NAC) Titles 404, 465, 471, 473, 474 and 480. Appropriate checklist(s) marked "Provider Addendum (name of service)" and other appropriate additions to the Agreement marked "Attachment 9A, B or C)" for contracted service is/are attached and by this reference are made part of this Agreement as if included in the contract word for word and the provider agrees to abide by all regulations as outlined in the attachment(s).

Par. 2 Agreement Effective Date from 3/13/09 through 02/28/10

Par. 3 Service(s) to be provided. (See corresponding service addendum.) DD = Developmental Disabilities

- | | | |
|--|--|---|
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Family Support | <input type="checkbox"/> Independence Skills Man. |
| <input type="checkbox"/> Adult Day Health | <input type="checkbox"/> Habilitative Day Care | <input type="checkbox"/> Nutrition Service |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Homemaker | <input type="checkbox"/> PERS |
| <input type="checkbox"/> Assisted Technology-DD | <input type="checkbox"/> Homemaker-DD | <input type="checkbox"/> PERS-DD |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Home Care/Chore | <input type="checkbox"/> Personal Assistance-Medicaid |
| <input type="checkbox"/> Community Living & Day Support-DD | <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Congregate Meals | <input type="checkbox"/> Home Modification-DD | <input checked="" type="checkbox"/> Transportation |
| | | <input type="checkbox"/> Vehicle Modifications-DD |

Section III

Terms of Agreement

- Par. 1** If the provider violates or breaches any of the provisions of this Agreement, then this Agreement may be terminated immediately, at the election of the Department. If there are any damages arising from such violation or breach, legal remedies may be pursued to recover such damages. Any money due to the provider, which accrued prior to such violation or breach, may be offset against the damages.
- Par. 2** Under the terms of this Agreement:
1. Staff will determine eligibility for services and authorize appropriate services for the individuals.
 2. Staff will notify provider if the service(s) being provided for a specific client is to be terminated or changed before the end of the authorization period.
 3. The Department will honor claims and make payments for services that were authorized and provided in accordance with the Department's policies and standards.
- Par. 3** This Agreement may be terminated by either party at any time by giving at least thirty days advance written notice to the other party to allow for arrangement of alternate service provision for clients. The notice requirement may be waived in case of emergencies such as illness, death, injury or fire. Only such payments as have already accrued for services rendered prior to the effective date of termination shall be made to the provider upon such voluntary termination.
- Par. 4** Subcontracting by an individual provider is not allowed under this Agreement.
- Par. 5** Service(s) will be provided using the following unit rate(s) within the maximum number of units authorized by the service area staff on a case-by-case basis.

Service Code	Service	Maximum Rate	Units
	SEE ATTACHMENT A		

Attach documentation of basic or specialized status of Medicaid Personal Assistant.

Par. 6 The above terms of this Agreement, Paragraphs 1 through 5 may be renegotiated upon agreement of both parties. The party requesting a change in the above terms must notify the other party at least sixty (60) days before the date the proposed change is to be implemented, except for rate changes due to minimum wage changes, rates regulated by governmental agencies or other changes required by law.

Section IV

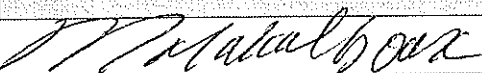
General Provider Standards

By signing this Agreement, the service provider agrees to:

1. Follow all applicable Nebraska Department of Health and Human Services' policies and procedures (Nebraska Administrative Code Titles 404, 465, 471, 473, 474 and 480).
2. Bill only for services which are authorized and actually provided.
3. Submit billing documents after service is provided and within 90 days.
4. Accept payment as payment in full (payment from DHHS plus the client's obligation) and assure that the rate negotiated or charged does not exceed the amount charged to private payers.
5. Not provide services if s/he is the legally responsible relative (i.e., spouse of client or parent of minor child who is a client).
6. Not discriminate against any employee, applicant for employment or program participant or applicant because of race, age, color, religion, sex, handicap or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60.
7. Retain financial and statistical records for six years from date of service provision to support and document all claims.
8. Allow federal, state or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20 – 74.24; and 42 CFR 431.107. Inspections, reviews and audits may be conducted on site.
9. Keep current any state or local license/certification required for service provision.
10. Provide services as an independent contractor, if the provider is an individual, recognizing that s/he is not an employee of the Department or of the State.
11. Agree and assure that any false claims (including claims submitted electronically), statement, documents or concealment of material fact may be prosecuted under applicable state or federal laws (42 CFR 455.18).
12. Respect every client's right to confidentiality and safeguard confidential information.
13. Understand and accept responsibility for the client's safety and property.
14. Not transfer this Agreement to any other entity or person.
15. Operate a drug free workplace.
16. Not use any federal funds received to influence agency or congressional staff.
17. Not engage in or have an ongoing history of criminal activity that may be harmful or may endanger individuals for whom s/he provides services. This may include a substantiated listing as a perpetrator on the child and/or adult central registries of abuse and neglect and/or the sex offender registries.
18. Allow Central Registry checks on himself/herself, family member if appropriate, or if an agency, agree to allow Department of Health and Human Services' staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect and law violations are in place.
19. Have the knowledge, experience and/or skills necessary to perform the task(s).
20. Report changes to appropriate Department staff (e.g., no longer able/willing to provide service, changes in client function).
21. Agree and assure that any suspected abuse or neglect will be reported to law enforcement and/or appropriate Department staff.

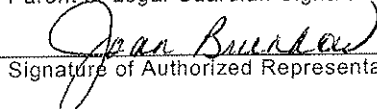
I certify that I have read and understand the standards as stated and referenced above and agree to comply with all the terms of this Agreement.

Section V


Provider/Agency Representative

3/13/09
Date

Parent or Legal Guardian Signature (if required)


Signature of Authorized Representative – Nebraska Department of Health and Human Services

Date
3-13-09
Date



N-FOCUS Provider Number

92029339

Transportation Service Provider Rate Agreement Addendum

Nebraska Department of Health and Human Services

CARING PEOPLE SUDAN**Par. 1 Agreement Effective Date from JULY 1, 2009 through FEBRUARY 28, 2010****Par. 2 SERVICE CODE 1965: TRANSPORTATION PER TRIP WITHIN DOUGLAS & SARPY COUNTIES:**

- \$12.50 per one way trip/ \$16.50 per scheduled round trip.
- Additional passenger is \$3.50 per one way trip only with prior-authorization.
- An Escort/Attendant identified on the authorization rides at no charge.
- A rate of \$3.50 may be charged for stops only with prior-authorization.

Provider Representative

Malakal Goak

Printed Name

9/3/09

Date

Signature of Authorized Representative - Nebraska Department of Health and Human Services

9-3-09

Date

In the Matter of the) APPLICATION NO. BR-347
Prescription of Reasonable)
Rates and Charges for Motor) GRANTED ON AN EMERGENCY
Carriers Passengers and) BASIS
Property for Hire subject to)
the Provisions of Neb. Rev.) ENTERED: MARCH 10, 2009
Stat. (Reissue 2003), Chapter)
75, Articles 1 and 3.	

BY THE COMMISSION:

OPINION AND FINDINGS

On March 9, 2009, Caring People Sudan, Omaha, Nebraska, filed an application for authority to establish rates for its use in its operations as follows:

Description	Proposed	
	One Way	Round Trip
Passenger within City limit	\$12.50	\$16.50
Additional stops within city limit	\$3.50 (per a stop)	
Additional person for escort of Passenger	\$ 5.50	\$ 7.50
Waiting time rates	\$ 5.00 (1/2 hr)	
Weekends/Holidays/After Hours	\$15.00 additional per appointment	

Emergency action is requested.

Applicant is a certificated common carrier which holds Certificate Number B-1714. The certificate allows the transportation of passengers and their baggage by contract by van for Employment First clients between points in Douglas and Sarpy counties, and between points in said counties, where public transportation is not available due to bus line restrictions. HHS designation: Yes. Restricted against the transportation of railroad train crews.

The Applicant received authority to operate from the Commission under Certificate No. B-1714 on October 29, 2008. The Applicant is establishing its rates for use in this certificate.

The Applicant represents to the Commission that the proposed rates are based upon anticipated expenses in

APPLICATION NO. BR-347

PAGE 2

vehicle maintenance, fuel expenses, insurance premiums, advertising and other overhead charges.

In applications such as these, the Commission must find that an emergency situation exists. Such a situation exists in this application as the Applicant cannot begin operations under its certificate as granted until the rates are approved.

Upon consideration of the application and being fully advised in the premises, the Commission is of the opinion and finds that the application should be granted on an emergency basis effective March 13, 2009.

ORDER

IT IS, THEREFORE, ORDERED by the Nebraska Public Service Commission that effective March 13, 2009, Caring people Sudan, Omaha, Nebraska, be, and it is hereby, authorized to establish rates for its use as follows:

Description	One Way	Round Trip
Passenger within City limit	\$12.50	\$16.50
Additional stops within city limit	\$3.50 (per a stop)	

Additional person for escort of		
Passenger	\$ 5.50	\$ 7.50
Waiting time rates	\$ 5.00 (1/2 hr)	
Weekends/Holidays/After Hours	\$15.00 additional	
	per appointment	

IT IS FURTHER ORDERED by the Nebraska Public Service that notice of this amendment to their rates be conspicuously displayed within each vehicle.

IT IS FURTHER ORDERED by the Nebraska Public Service Commission that public notice of this action be published in the Daily Record, Omaha, Nebraska, pursuant to the provisions of Section 75-121. R.R.S. 2006, and the Commissions Rules.

**Request for Taxpayer
Identification Number and Certification**

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return) CARING PEOPLE SUDAN	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Other (see instructions) ▶	<input type="checkbox"/> Exempt payee
Address (number, street, and apt. or suite no.) 2523 Himebaugh Ave	Requester's name and address (optional)
City, state, and ZIP code Omaha, NE 68111	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number 20-3615736

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶ Malakal Boak	Date ▶ 3/13/09
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,